

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>15G521</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/05/2013</b>	
NAME OF PROVIDER OR SUPPLIER  <b>AWS</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>7614 LAMLIE RD</b> <b>FORT WAYNE, IN 46818</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	<p><b>INITIAL COMMENTS</b></p> <p>A Life Safety Code Certification and Environmental Preoccupancy Survey for the addition of 2 beds was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 12/05/13</p> <p>Facility Number: 001035 Provider Number: 15G521 AIM Number: 100239820</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code and Environmental Preoccupancy survey, AWS was found in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies and with 410 IAC 9, Community Residential Facilities for Persons with Developmental Disabilities.</p> <p>The one story facility was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in sleeping rooms and in common living areas. The facility has a capacity of 6 and had a census of 4 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.6.</p>			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1  Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/09/13.	K 000			